STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155291	A. BUILDING 01 B. WING	01/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE VALLEY MEADOWS	3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/16/13 Facility Number: 000188 Provider Number: 155291 AIM Number: 100266310 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Eagle Valley Meadows was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping	K0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a Post Survey Review on or after 02/14/13.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	rooms. The facility has a capacity of 115 and had a census of 92 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has one detached building, a wooden storage shed, providing facility services which was not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/23/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review, observation and interview; the facility failed to develop a written fire safety plan for staff response to the activation of battery operated smoke detectors installed in 61 of 61 resident sleeping rooms. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Disaster Action Plan: Fire Prevention and General Action Fire Plan" documentation with the Administrator during record review from 9:30 a.m. to 11:35 a.m. on 01/16/13, the facility's written fire safety plan did not	K0048	It is the practice of this provider to ensure there is a written plan for protection of all patients and for their evacuation in the event of an emergency. 1. The Disaster Action Plan for the facility was updated to include staff response to the activation of battery operated smoke detectors installed in each resident sleeping room by the Execuitve Director. 2. All residents have potential to be affected by this deficient practice. 3. The Disaster Action plan for the facility was updated by the Execuitve Director. All staff re-educated on the action fire plan for the facility by the Maintenance Director by 02/14/13. 4. Disaster Training will be provided to staff quarterly by the SDC/designee. The Executive Director will review the Disaster Action Plan annually to ensure accuracy.	02/14/2013

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	include staff response to the activation of battery operated smoke detectors installed in each resident sleeping room. Based on observations with the Administrator and the Housekeeping Manager during a tour of the facility from 11:35 a.m. to 1:50 p.m. on 01/16/13, battery operated smoke detectors were installed in each resident sleeping room. Based on interview at the time of record review, the Administrator acknowledged the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors in resident sleeping rooms. 3.1-19(a)			

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K0050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 1. Based on record review and interview, the facility failed to document fire drills conducted on the first, second and third shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Monthly Fire Drill Report" documentation with the Administrator during record review from 9:30 a.m. to 11:35 a.m. on 01/16/13, documentation of a fire drill conducted on the second and third shift for the first quarter of 2012 and on the first shift for the fourth quarter of 2012 was not available for review. Based on interview at the time of record review, the Administrator acknowledged documentation of fire drills conducted on the aforementioned shifts was not available for review.	K0050	It is the practice of this provider to ensure fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of the established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 pm and 6 am a coded announcement may be used instead of audible alarms. 1. The Maintenance Director was re-educated on the fire drill shift/time stagger worksheet by the Executive Director by 02/14/13. 2. All residents have the potential to be affected by this deficient practice. 3. Fire drills will be performed once per shift per quarter by the Maintenance Director and or designee. 4. The Executive Director will reveiw the monthly fire drill reports quarterly to ensure the drills are held on	02/14/2013

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	3.1-19(b) 2. Based on record review and interview, the facility failed to document transmission of the fire alarm signal for fire drills conducted prior to 9:00 p.m. on the second shift for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Monthly Fire Drill Report" documentation with the Administrator during record review from 9:30 a.m. to 11:35 a.m. on 01/16/13, documentation for the second shift fire drill conducted on 04/17/12 at 5:15 p.m. did not include transmission of the fire alarm signal. The documentation for the aforementioned fire drill recorded "No" in response to the drill record statements of "was action taken to activate the fire alarm system" and "was it verified that the monitoring service received the alarm." Based on interview at the time of record review, the Administrator acknowledged documentation of the second shift fire drill conducted on 04/17/12 at 5:15 p.m.		each shift.	

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	did not include transmission of the fire alarm signal. 3.1-19(b)			

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K0130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 50 residents, staff and visitors in the Main Dining Room. Findings include: Based on record review with the Administrator from 9:30 a.m. to 11:35 a.m. on 01/16/13, documentation of an annual rolling fire door inspection was	K0130	It is the practice of this provider to ensure the care and maintenance of rolling fire doors are in accordance with NFPA 80. 1. The rolling fire door was inspected on 01/16/13 by Integrated Electronics. 2. All residents who use the main dining room have the potential to be affected by this deficient practice. 3. The rolling fire door will be inspected annually by Integrated Electronics. The annual inspection reminder was added to monthly tasks for December, 2013. 4. The Maintenance Director will review inspection records quarterly to ensure they are completed timely.	02/14/2013

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	not available for review. Based on observation with the Administrator and the Housekeeping Manager during a tour of the facility from 11:35 a.m. to 1:50 p.m. on 01/16/13, the rolling fire door protecting the opening from the kitchen to the Main Dining Room had an inspection tag indicating the most recent annual inspection of the rolling fire door was performed in December 2011. Based on interview at the time of record review and observation, the Administrator acknowledged it has been more than one year since the most recent annual inspection was of the rolling fire door was performed to check for proper operation and full closure . 3.1-19(b)			

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K0144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 1 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of	K0144	It is the practice of this provider to ensure generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 1. The Maintenance Director was re-educated on weekly and monthly generator testing and the preventative maintenance schedule by the Executive Director. 2. All residents have the potential to be affected by this deficient practice. 3. The Maintenance Director will complete the monthly load test and weekly inspection checklist according to the facility preventative maintenance schedule. 4. The Executive Director will review the Preventative Maintenance Schedule monthly to ensure completion.	02/14/2013

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	inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator-Weekly Exercise/Monthly Load Test Log" documentation with the Administrator during record review from 9:30 a.m. to 11:35 a.m. on 01/16/13, monthly load test documentation for February 2012 was not available for review. Based on interview at the time of record review, the Administrator acknowledged documentation of monthly load test documentation for February 2012 was not available for review. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 3 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be			

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	maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator-Weekly Exercise/Monthly Load Test Log" documentation with the Administrator during record review from 9:30 a.m. to 11:35 a.m. on 01/16/13, weekly emergency generator starting battery inspection records for the three week period of 02/21/12 through 03/07/12 was not available for review. Based on interview at the time of record review, the Administrator acknowledged documentation of weekly battery inspections for the three week period of 02/21/12 through 03/07/12 was not available for review.			

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